



MARICOPA MEDICAL CENTER

DEPARTMENT OF INTERNAL MEDICINE
2601 E. ROOSEVELT STREET, ROOM 0-D-10
PHOENIX, AZ 85008

CONTACT: Karen Boettcher, Clerkship Coordinator
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Clinical Clerkship/Elective or Observer Application ~~ (please type or print)

ROTATION REQUEST

All rotations are 4 weeks. Must submit 60 to 90 days prior to requested start date.

ROTATION TITLE (My 1st preference)

INCLUSIVE DATES

(2nd preference - if 1st preference is unavailable)

INCLUSIVE DATES

(3rd preference - if 2nd preference is unavailable)

INCLUSIVE DATES

PERSONAL DATA

Name in Full (First, Middle, Last): _____

Social Security # _____ DOB: _____

Permanent Address: _____

Home Telephone: _____ Cell Phone/Pager: _____

Fax: _____ E-Mail Address: _____

Emergency Contact: _____ Telephone: _____

EDUCATION

Undergraduate School: _____

Mo/Yr to Mo/Yr: _____ Degree: _____

Medical School: _____

Mo/Yr to Mo/Yr (expected date of graduation): _____

If Foreign Medical Student, date of examination: _____ Diploma Issued on: _____

CLERKSHIP

If you have previously completed any clerkships/elective/rotations at Maricopa Medical Center, indicate rotation and inclusive dates:

ROTATION #1: _____ DATES: _____

ROTATION #2: _____ DATES: _____

OTHER

❖ Have you ever been charged with a violation (excluding traffic violations) of any statute of any state, the U.S. or any foreign country? ☐ No ☐ Yes

❖ In order for my application to be complete, I have attached the following documents:

- ☐ Curriculum Vitae
- ☐ USMLE/COMLEX/ECFMG Scores Part I & II (as appropriate)
- ☐ Letter from the Dean of your Medical School stating approval of this rotation and class rank
- ☐ Immunization Record (TB must be current – within 12 months of requested rotation)
- ☐ Certificate of Liability Insurance from your medical school
- ☐ Certificate of Personal Health Insurance
- ☐ Verification of HIPAA training
- ☐ Copy of School ID, Passport or State Issued ID Card

I hereby certify that the information I submit in this application is complete and correct to the best of my knowledge and belief (must be signed to process application).

Applicant Signature

Date

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OFFICE USE ONLY:

Coordinator Approved on: \_\_\_\_\_ Comments: \_\_\_\_\_

Department Approved Dates: \_\_\_\_\_

Department Approval: \_\_\_\_\_